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INSIDE

RELIAS MEDIA

All Financial Conflicts of Interest Influence Findings: 'There's Always a Tradeoff Involved'

New data fuel ethical worries on industry ties

All financial conflicts of interest (COI) influence whether study authors report findings favorable to industry sponsors, according to a recent investigation.[1]

"Historically, some industry-sponsored studies have had significant influence on the public, our patients, and our healthcare system," says **Karla Bernardi**, MD, one of the study's authors. When these studies were repeated by independent researchers, some findings were shown to be erroneous.

"In addition, there has been increased attention on individuals and institutions failing to fully disclose and manage their ties with industry," says Bernardi, a general surgery research fellow with McGovern Medical School at The University of Texas Health Science Center at Houston.

> "THERE HAS BEEN INCREASED ATTENTION ON INDIVIDUALS AND INSTITUTIONS FAILING TO FULLY DISCLOSE AND MANAGE THEIR TIES WITH INDUSTRY."

These well-publicized failures raised the question of whether industry influenced the results reported by researchers. The investigators reviewed 590 research articles to determine if authors who fail to disclose reportable COI are more likely to publish findings that are favorable to industry than authors with no COI. Two key findings:

- a 69% discordance rate existed between industry and self-report in COI disclosure;

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• when authors failed to disclose COI, their findings were more likely to favor industry partners than authors without COI.

"Our team was surprised to find that any conflict of interest — relevant or not relevant, disclosed or undisclosed — will influence scientific reporting compared to studies with no financial conflict of interest," says Bernardi.

Need for Monetary Support

To conduct a well-structured trial, a researcher needs a substantial amount of capital. "Medical research has become more expensive over time. Unfortunately, there is not enough funding for all projects that individuals want to perform," says Bernardi.

Industry is a leading source of monetary support for possible advancements in medicine. "However, our study found that any conflict of interest affects the reporting of scientific studies," notes Bernardi. For this reason, the researchers support the National Academy of Medicine (formerly the Institute of Medicine [IOM]) recommendation, she notes: "The IOM suggests that any individual with a conflict of interest should not be involved in human research."

The main ethical message from the study's findings, says **Matthew McCoy**, PhD, is that there is no such thing as a risk-free financial conflict. "Any kind of financial conflict has the potential to bias research," says McCoy.

It is possible that benefits associated with a particular financial conflict — for instance, funded research — might outweigh the risk of bias. "But individuals and institutions need to acknowledge that there's always a tradeoff involved," says McCoy, an assistant professor in the department of medical ethics and health policy at the University of Pennsylvania's Perelman School of Medicine.

Disclosure Alone Does Not Neutralize

Given the potential for bias, it is important that all conflicts be disclosed so they can be evaluated. "But second, and more importantly, it's important to recognize that disclosure doesn't neutralize the risk of bias," says McCoy. It is a mistake to assume that just because a financial conflict is disclosed that there is no reason to worry about it.

It is unclear to what extent, if any, research institutions will revise polices in the wake of increased scrutiny.

EXECUTIVE SUMMARY

All financial conflicts of interest influence whether study authors report findings favorable to industry sponsors, found a recent study.

- There is more attention on individuals and institutions failing to fully disclose industry ties.
- When authors failed to disclose, their findings were more likely to favor industry partners.
- Disclosure of conflicts does not neutralize the risk of bias.

"But to the extent that institutions are taking this opportunity to review and revise COI polices, they ought to involve ethicists in the process," says McCoy.

One way to achieve this is to include ethicists on COI committees. Raising awareness also is an important ethics role, says McCoy.

"Ethicists can help to inform and educate the public about the importance of COI in medicine and what can be done to address them," he says. ■

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The Immediate and Downstream Benefits of Ethics Rounds

Ethically problematic issues resolved earlier

At Michigan Medicine, **Janice Firn**, PhD, MSW, conducts weekly "preventive ethics rounds" at the health system's nine ICUs. For both ethicists and clinicians, it is a good chance to build relationships.

"Collaboration is fostered. It doesn't feel like you have to wait for a huge conflict in order for the ethicist to get involved," says Firn, a clinical ethicist at the Center for Bioethics and Social Scientists in Medicine at the University of Michigan Medical School.

Ethicists found the preventive ethics approach affected the number and nature of ethics consults. "We've identified patient, provider, and system risk factors that, if unaddressed, could result in the need for a formal consult," says Firn.

All Kinds of Questions

An example would be a patient admitted to the ICU with a diagnosis of severe and persistent mental illness. This could affect autonomy and medical decision-making. "Lack of stable preferences over time could complicate the surrogate's ability to use substituted judgment," notes Firn.

Providers may misunderstand how mental health diagnoses affect a patient's capacity. Additionally, patients with severe mental illness are less likely to have had an advance care planning discussion with providers. "With regular rounding, these issues can be addressed early in the admission instead," says Firn.

Clinicians who are exposed to ongoing ethics education are able to resolve many issues on their own. "There is a very low bar for asking all kinds of questions," says Firn. "There is also an opportunity to build a common language."

Clinicians sometimes experienced a gut feeling something was not right, or thought an intervention was the "right" thing to do. Now, clinicians can describe this feeling using ethical language. For instance, clinicians may believe a surrogate decision-maker is choosing an option that is not in the patient's best interest. But if the decision is consistent with the patient's own values, the ethicist can point out that the decision is ethically permissible.

Rounding does not eliminate the need for formal consults. "But they're happening earlier in the process. They are less contentious and more amenable to resolution," says Firn.

EXECUTIVE SUMMARY

Regular rounding by ethicists builds trust with clinicians and gets issues resolved earlier. Other benefits include:

- Clinicians learn to use ethical terminology;
- Moral distress is identified and mitigated;
- Other hospital departments prioritize advance care planning and identifying patients' preferences.

Most clinicians underwent some type of ethics education as medical students. Seeing ethics applied to actual patients "is a really different thing," says Firn. "Every time I'm up there, I'm providing education. But it's case-based, and with teams."

ICU clinicians voiced a recurring ethical concern, involving patients who can respond verbally and refuse or ask for treatment, but lack decision-making capacity. During ethics rounds, Firn explained why it's ethically acceptable to provide or withdraw treatment that is consistent with the patient's expressed wishes, goals, and values.

Although ethics rounds take just 15 to 30 minutes, a surprising amount of ground is covered. Moral distress is sometimes voiced in one way or another. "Rounds act as a way to create moral space for reflection," says Firn.

Clinicians can debrief as an interprofessional team about emotionally challenging cases in real-time while the case is ongoing. "Unless we create little pauses, the system keeps going. But the system can't tolerate really long pauses," says Firn.

Some clinicians thought the ethicist's role was to tell everyone what was ethically appropriate. They now realize that ethicists consider the viewpoints of stakeholders and identify ethically acceptable alternatives. "Not everybody will participate in a formal consult process," says Firn. "This gives more people the opportunity to have an interaction with ethics."

An Uninvited Guest

Weekly medical ICU (MICU) rounding is a chance to briefly teach staff and trainees about relevant ethics, palliative care, and geriatrics issues, according to the authors of a recent paper.[1]

"I thought of myself as an uninvited guest on the ICU team's morning rounds. I felt that it was important for me to let them do their work, not interrupting too much," says **Elizabeth K. Vig**, MD, MPH, chair of the ethics consultation service at VA Puget Sound Health Care System in Seattle.

When Vig spoke up, she made her points succinctly. "Many of the attending physicians and nurses on the unit already knew me from times when I had done palliative care consults on the unit. I think this helped them trust me," says Vig, who was present for discussion of about 200 patients per year.

Some potential future conflicts were dealt with on rounds, so they never resulted in formal ethics consults.

"For example, if the team mentioned difficult family dynamics, I'd want to make sure that the patient had designated someone he or she trusts as surrogate decision-maker," says Vig.

During the first two years after rounding was implemented, the number of ethics and palliative care consults from the MICU increased somewhat. In part, this was because the team was more aware of the relevant ethical issues and the potential for palliative care support.

"Ethics and palliative care are going to be on people's radar more if someone from those disciplines is standing right there on rounds," says Vig.

Downstream Effects

It was not surprising that individual clinicians gained ethics expertise. "What I hadn't thought about before starting the project were the downstream effects," says Vig.

For instance, a dietician who attended ICU rounds learned about Physician Orders for Life-Sustaining Treatment (POLST) forms. These include a section about preferences for feeding tube use.

"She began encouraging medical teams to consult patients' POLST forms when deciding about placement of feeding tubes," says Vig.

Additionally, because of the ethics rounding, hospital staff prioritized reviewing advance directives of newly admitted patients and identifying their legal decision-makers. "This may help prevent ethical dilemmas," says Vig.

Including someone with ethics knowledge on rounds provides an opportunity to consider ethical issues that arise in taking care of seriously ill people. "Hopefully, this awareness remains when that person isn't present," says Vig. ■

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New Efforts Help Emergency Medicine Residents Gain Hospice, Palliative Medicine Skills

Goal is not necessarily 'full speed ahead to the ICU'

ED providers see patients with serious, life-limiting illness every day. "Our training has traditionally been focused on resuscitation and fixing the problem. But the reality is that some patients are not there for a cure," says **Eric Isaacs**, MD, clinical professor of emergency medicine at Zuckerberg San Francisco General Hospital.

In fact, many patients go to the ED to address pain, fear, symptom control, or just the need for communication. Good care, says Isaacs, "doesn't always mean full speed ahead to the ICU. Sometimes, it means taking a little bit of time to ask questions and recognize that the situation might call for a different approach."

However, emergency medicine (EM) residents have very little time to learn hospice and palliative medicine skills. This includes symptom management and effective communication. There currently is no nationally defined hospice and palliative medicine curriculum for EM resident training.

"For decades, people have assumed that the ED is a place you go to be resuscitated, and that the only thing we know how to do is put our foot on the accelerator, so to speak, and push for aggressive care," says Isaacs.

ED providers feel ethically conflicted about providing aggressive care when it seems inappropriate. "If you talk to emergency physicians who've been doing this for 25, 30 years, they never thought it was the right thing to do. But they didn't have the skill set to take care of these patients," says Isaacs.

> "OUR TRAINING HAS TRADITIONALLY BEEN FOCUSED ON RESUSCITATION AND FIXING THE PROBLEM. BUT THE REALITY IS THAT SOME PATIENTS ARE NOT THERE FOR A CURE."

There is growing recognition that the ED providers play a key role in preventing unwanted care and hospitalizations. "If we can talk to the patients and their families, learn about their values and hopes, and give the right care at that time, we are making a huge difference," says Isaacs.

An expert consensus group set out to develop hospice and palliative medicine milestones within a competency framework, relevant to the ED setting.[1]

"The group decided that one of our first projects would be to see if we could come up with a suggested framework for residency program directors to use in assessing and developing EM resident skills," says **Jan Shoenberger**, MD, who served on a subcommittee on curriculum development.

The group identified relevant knowledge, skills, and behaviors. Their framework was modeled after the widely accepted Accreditation Council for Graduate Medical Education (ACGME) EM milestones.

"We knew that it was something that residency directors were comfortable and familiar with," explains Shoenberger, vice chair of operations and clinical education in the department of emergency medicine at Los Angeles County and USC Medical Center.

All subcommittee members were emergency physicians who had an interest and training in hospice and palliative medicine. Many are board-certified in hospice and palliative medicine in addition to emergency medicine.

"Also, many of us have expertise in

EXECUTIVE SUMMARY

New programs ensure emergency medicine residents learn hospice and palliative medicine skills.

- Currently, there is no nationally defined hospice and palliative medicine curriculum for emergency medicine resident training;
- ED providers may feel ethically conflicted about providing aggressive care;
- Residency programs vary in how much palliative medicine skills are taught, if at all.

education," says Shoenberger, a former EM residency program director. "Going forward, we knew that the ACGME will eventually publish and develop a new version of the milestones for emergency medicine."

The group hopes their effort would stimulate some thought from the ACGME on adding a separate milestone for these skills or integrating some of the language into existing milestones.

"We would like it to be something that is assessed and measured during residency training in EM," says Shoenberger.

For hospital ethicists, the work signals the desire of the EM community for improved expertise in dealing with end-of-life issues. "We believe that one good way to address this need is through asking our residency programs to integrate these skills into their curricula," says Shoenberger.

Palliative care in emergency medicine is relatively new, notes Isaacs, chair of the American College of Emergency Physicians' palliative medicine section. Not all training programs include palliative care "champions" to advocate for the inclusion of these skills. "In fact, there are probably about 150 board-certified emergency physicians who are also board-certified in palliative medicine. And many of them are in the same place," says Isaacs.

Some programs have achieved buy-in from their residency administration to include these skills. In other programs, there is almost no training at all. "And if it is being done, it isn't being done very well," says Isaacs. Residents appreciate gaining the expertise. "What I'm seeing now is that residents are sharing some of the nuances and skills in this area even with their supervisors, who may not have been trained accordingly," says Isaacs.

Historically, the discipline of emergency medicine managed acute problems. A growing number of people who are chronically, and perhaps terminally, ill are presenting to EDs. "More and more, we realize that we set the stage for what happens to the patient in the healthcare trajectory," says **Sangeeta Lamba**, MD, associate dean of education at Rutgers New Jersey Medical School.

EM residents need expertise to manage this burgeoning patient population, as ED care plays a big role in the management of their last stages of life. "Our discipline has to grapple with whether we are giving the right tools not just for acute care, but also for patients who are chronically and perhaps even terminally ill — because the same rules do not apply," says Lamba. ED providers need to evaluate if the patient values quality over quantity of life; for instance, a person with congestive heart failure may not wish to live out their last few days in the hospital.

Gathering pre-existing documentation on code status, healthcare proxies, or advance care planning becomes very important in the ED.

"It goes beyond the question of whether the patient should be on a ventilator or not," says Lamba.

Even if the patient does end up going to the ICU, says Lamba, "the team is already aware, the family is already engaged, and there is less conflict later." ■

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Social Media Research Presents Many Unresolved Ethical Issues

Direct-to-consumer wellness products, location-tracking apps, and access to personal data on social networks present both exciting opportunities and significant ethical worries for researchers.

"The digital revolution is rapidly influencing how health research is conducted. We can now passively observe and record people 'in the wild' and 24/7," says **Camille Nebeker**, EdD, MS, founder and director of UC San Diego's Research Center for Optimal Data Ethics.

The use of artificial intelligence and active assisted living robots in the health sector also is increasing. "While there is amazing potential, the digital health ecosystem is not consistently regulated. We are in the Wild West of digital health research," says Nebeker.

The authors of a recent paper propose steps the scientific community can take to ensure social media data are used ethically.[1] The paper was prompted in part by the recent Cambridge Analytica scandal, involving allegations that the firm used data improperly obtained from Facebook to build voter profiles.

"Many of my colleagues are conducting research using social media platforms," says Nebeker, one of the paper's authors.

Institutional review boards (IRBs) and researchers are struggling to navigate this new territory, sometimes unsuccessfully.

"When something goes wrong, as it did with Cambridge Analytica, it compromises public trust and jeopardizes research that is in progress," says Nebeker.

The following are two central ethical concerns:

• Researchers may need to cover additional information during the informed consent process.

Commercial products — such as fitness tracking devices — are used as measurement tools. This means privacy policies and terms of service should be considered.

"These terms might influence the study risk assessment," explains Nebeker. Potential research participants also need to factor in this information to make informed decisions.

"In many cases, the terms of service directly conflict with the federal regulations for human subjects protections in that a participant, if harmed by the product, must agree to arbitration," notes Nebeker.

• Not all tech companies comply with federal requirements for research.

Federal regulations for human subjects protections must be followed if research is funded by the U.S. Department of Health and Human Services. However, many tech companies that are involved in biomedical research are not regulated. "We need to develop common standards that govern digital health research," says Nebeker.

Researchers using social media data are operating in an unregulated environment. Thus, there is growing concern about potential harms. "This is another case of how technology has evolved faster than regulations," says **Sherry Pagoto**, PhD, director at the University of Connecticut Center for mHealth and Social Media.

Privacy breaches are possible — intentional or not. "This poses risks to everyone involved: researchers, social media companies, and, most importantly, the general public," says Pagoto.

For example, few Twitter users are aware that public social media posts can be used by researchers.[2] Notably, the majority believe that researchers should not be able to use their tweets without consent. Also, users of commercial products do not always understand privacy implications.

"We cannot fault them, though. These policies are very lengthy and written in ways that are difficult to understand," says Pagoto.

The following changes are needed, according to the study authors:

• Public education on the research performed with social media data, why it is important, and how researchers protect user privacy.

"Consultation with an expert in health tech ethics is critical if being proactive and diligent about human research protections," says Nebeker.

Stakeholders — including researchers, IRBs, potential participants, or policymakers — may not be fully aware of how data are collected, used, or shared by social media platforms. "This lack of knowledge will influence risk assessment and information included in the informed consent process," notes Nebeker.

• Federal regulations on the use of social media data in research.

"We can anticipate that the technology and research landscape will only continue to evolve, and rapidly," says Pagoto. IRBs rely on federal regulations for guidance on the ethical conduct of research. These regulations are outdated as it pertains to the use of data generated by new technologies like social media. Thus,

says Pagoto, "universities, funders, and researchers need to be more vigilant about potential harms and begin to craft guidelines for the purpose of self-policing. We need a code of conduct."

• "Tech ethicists" working alongside researchers as they attempt to use social media data.

Someone with tech ethics expertise could comment on the ethical implications specific to technology used in studies and conduct training for clinicians. "It would also be useful for these folks to advise on grant applications, even serving as consultants or co-investigators," says Pagoto.

Someone on the IRB could take on this role. "But if limited expertise is available on campus, external expertise should be commissioned," says Pagoto.

IRBs also should have the expertise to properly review social media research. "Adequately attending to research ethics will require an investment," says Pagoto. "We want to nudge institutions to make this investment." ■

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Assumptions on Correct Surrogate Are Legally, Ethically Problematic

Someone comes to visit an ICU patient regularly and is assumed to be the next of kin. "The person ends up making decisions when it really was the cousin who happened to be visiting but only spoke to the patient yearly to wish him a happy birthday," says **Alvin H. Moss**, MD, a professor at West Virginia University's Center for Health Ethics and Law in Morgantown.

A significant number of ethics consults at West Virginia University Hospitals involved this kind of scenario. In one case, a patient's sister accompanied him to the ED and was assumed by everyone to be the surrogate. It was later discovered she had not seen her brother in years and they rarely spoke. "She just happened to be with him at the time he had a medical crisis," says Moss. On the other hand, the patient's son saw his father regularly but was an alcoholic. Clinicians called ethics, concerned that the son was not a suitable surrogate due to his alcoholism. Ethicists explained that this fact alone would not automatically disqualify the son as a surrogate. "It was a matter of establishing that the son had decision-making capacity, and that he really did know his father's wishes," says Moss.

Often, lack of familiarity with state laws caused confusion. "Our physicians come from any number of different states, and they were not typically oriented to healthcare law in the state in which they were practicing," explains Moss.

Ethicists held a series of workshops on the appropriate ethical and legal order for surrogate selection. Included were care management social workers, who typically were tasked with assisting in surrogate selection according to state law. "This decreased the number of times we were called," says Moss.

Some states list a specific order, allowing for no flexibility. Others, including West Virginia, do allow flexibility if the person with highest priority on the list is not the best choice because that person does not know the patient's wishes.[1,2] "If someone knows the patient's wishes better and has had more regular contact with the patient, that person would be the appropriate surrogate," Moss says. Ideally, the surrogate is available to make face-to-face decisions with the healthcare team.

"One of the things ethics consultants need to do is to pin down what authority does the person really have? And, do they have any documentation at all?" asks Moss.

Some individuals have claimed to be the surrogate without anything to prove it. In some cases, a patient's durable power of attorney incorrectly assumes this status allows them to make medical decisions on the patient's behalf. Others ask to be appointed as surrogate because they believe it will give them authority over how the patient's assets are distributed.

Ethicists explain: The law is very clear that the healthcare surrogate only has authority for healthcare decisions. "Sometimes, they are not very subtle. They ask us if they will now have the authority to cash checks," says Moss.

One family member, furious that

she was not named as surrogate, ended up suing the hospital. In part to discourage such frivolous lawsuits, the West Virginia Network of Ethics Committees worked to amend the process for appointing surrogates and appealing the appointment. "In the early years of our new surrogate healthcare law, we found people were very eager to challenge the surrogate selection decision," says Moss. State law was amended to say that if the hospital appointed the surrogate in a good faith effort and the person challenging the decision loses, he or she is responsible for the court costs.

"There are a lot of states that don't have nearly as good a process for selecting a healthcare surrogate," says Moss.

A patient with a same-sex partner who has not completed an advance directive and designated a medical power of attorney representative, and has no ties with his or her next of kin, is one example of a scenario where ethical and legal obligations could end up in conflict.

"In some states with an inflexible priority order, following the law explicitly would mean the parents would be the ones getting to make decisions when the parents have been out of the patient's life for years," says Moss.

Generally speaking, ethicists consider three things: Who has had regular contact? Who has shown care and concern? And who knows the patient's wishes best?

"You need to sort out what are the relationships the patient has with people who may potentially be surrogates," says Moss. For instance, ethicists sometimes call the primary care physician as part of the data-gathering.

"In doing ethics consultation, sometimes we need to do a bit of investigation. We look for misinformation, missing information, and miscommunication," says Moss. ■

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Dementia Program Linked to High Hospice Use, Low Acute Care Utilization

Patients participating in a comprehensive dementia care co-management program were highly involved in advance care planning, high rates of hospice use, and lower acute care visits near the end of life, according to a recent study.[1]

The study followed 322 persons enrolled in dementia care after July 1, 2012, who died before July 1, 2016. Key findings include the following:

- Nearly all had goals of care documented, and 64% created advance care plans.
- Among those with recorded preferences, 88% indicated do not resuscitate, 48% preferred limited medical interventions, and 35% requested only comfort care.
- Eighty-nine percent of patients requested little artificial nutrition and no feeding tubes.
- Fifty-four percent had no hospital admissions or ED visits in the last six months of life, and only 5% required ICU stays.
- Overall, 69% died on hospice; completion of Physician's Order for Life-Sustaining Treatment (POLST) form indicated higher likelihood of dying in hospice.

For any patient with impaired decision-making ability, says **David A. Fleming**, MD, MA, MACP, "the overarching concern is that their values, beliefs, and preferences be recognized and respected to the extent possible when important treatment decisions must be made."

This is particularly challenging for patients with dementia due to the long timeline that often exists for the patient's incapacitated state. Yet only about one-third of U.S. adults have completed an advance directive, found a recent analysis of 150 studies involving almost 800,000 people.[2]

"But the majority have, at some point in their life, commented to loved ones about the kind of life they would want to live in their final days," says Fleming, co-director and scholar at University of Missouri's Center for Health Ethics.

It is often "clear and convincing evidence of these discussions," as represented by loved ones, says Fleming, that preserves the ability to hear the patient's voice when he or she is incapacitated and now nearing the end of life.

"Structured care management programs offer the opportunity to work closely with both patients and their caregivers over an extended period of time," notes

Fleming. Clinicians gain a better understanding of the medical circumstances and values important to both the patient and caregivers.

"Developing a shared understanding of decisions that are in the best interest of the patient offer the opportunity to maximize care, while minimizing unnecessary hospitalization and treatments that are contraindicated," says Fleming. ■

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Chaplains Can Have 'Huge Impact' on Patient Care — If They Are Called

As an acute care nurse working in the ED or ICU, **Lisa Ruth-Sahd**, DEd, RN, CEN, CCRN, CNE, often saw grieving families she thought could be assisted by the hospital's chaplain. Often, social workers or counselors were called in, but not chaplains.

"I realized the huge impact chaplains can make as a team collaborator. I did not see them being utilized to their potential," says Ruth-Sahd, a professor in the Stabler Department of Nursing at York College of Pennsylvania.

Critical care nurses need to incorporate board-certified chaplains' contributions into the patient plan of care during bedside report, the authors of a recent paper argued.[1]

"Chaplain involvement provides a holistic dimension to patient care," says Ruth-Sahd, the paper's lead author. Ruth-Sahd suggests that chaplains can increase their presence and involvement in the following ways:

• Hold educational sessions to clarify their practice parameters and scope of practice to dispel the misconception that chaplains should be summoned only on matters of life or death;

• Make themselves more visible by participating in rounds instead of waiting to be called by clinicians;

• Post an informative sign at the hospital's main entrance introducing the chaplain and how he or she can be contacted;

• Support the clinical team during debriefings by identifying what could have been improved from a spiritual perspective.

"Being certain that a chaplain is a member of the ethics committee would also be beneficial," adds Ruth-Sahd.

Chaplains can help mediate critical clinical decisions. Rabbi **Susan Harris**, MHL, BCC, the director of chaplaincy at Boston Children's Hospital, authored a recent paper on this topic.[3] One reason chaplains are underutilized is persistent misconceptions on their role. Recently, a department head introduced Harris to another administrator as "the hospital's clergy."

"Chaplaincy is not always about religion. In fact, increasingly it's less about religion," says Harris.

When chaplains are pigeonholed in this manner, one response is to offer a detailed explanation on their true role. "But that is really annoying to the person who has to listen. Instead, we just have to do our role," says Harris.

Some physicians struggle with communication skills, especially when it comes to end-of-life care. "But the amount of responsibility they have on them is incredible," says Harris. "Physicians don't necessarily understand that the chaplain is there for them, as well."

Ethicists, clinicians, and chaplains play distinct roles. "But we are all in the business of enhancing communication and serving the needs of the patient and supporting the staff," says Harris.

Sometimes, chaplains are the only ones who pick up on the fact that the family is misunderstanding what the clinical team is saying. Other times, the family is not explaining themselves in a way that the clinical team can comprehend. "Addressing spiritual and existential distress is important to outcomes — and perceived outcomes," says Harris.

Sometimes the chaplain is silent the entire time during a family meeting or ethics consult. "But afterward, by virtue of having been there, we are in a much better position to help the family and to continue to enhance communication between both sides," says Harris.

About a year ago, ethicists at Boston Children's Hospital started participating on multidisciplinary rounds. Ethicists also check in with the bedside nurses when there

are difficult cases. "It is such as wonderful co-support role that we share," says Harris. "I feel like we are doing different parts of the same job together."

The number of ethics consults has since decreased. "That is a very good sign because the problems are being dealt with in real time," says Harris.

Chaplains have always been involved in ethics, and now staff is being informally schooled in ethics as well. "That just raises the level of conversation for everyone," says Harris. ■

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Oregon POLST Being Completed More Often and Earlier

Researchers wanted to see how the use and timing of Physician Orders for Life-Sustaining Treatment (POLST) completion has changed over time. A recent analysis compares two points in time — 2010 to 2011, and 2015 to 2016.[1]

"The study had several remarkable and unexpected findings," says study co-author **Susan Tolle**, MD, director of the Oregon Health & Science University (OHSU) Center for Ethics in Health Care and professor of general internal medicine and geriatrics in the OHSU School of Medicine. Tolle is chair of the Oregon POLST Coalition and a leader behind the development of the POLST program.

Some key findings of the analysis include the following:

• Researchers found a 46.6% increase in POLST registry use.

"POLST-like programs are being more widely implemented across the country, and Oregon has the longest history of use and the most widespread implementation," notes Tolle.

Of Oregonians who died between 2015 and 2016, 45% had POLST forms in the registry, compared with about 31% between 2010 and 2011. The largest increase was in patients aged 95 or older.

• There were substantial increases in time from POLST completion to death.

The length of time between form completion and death increased from an average of five weeks to 21 weeks.

• More Oregonians at end of life are indicating via POLST that they want more extensive medical care.

"While the most common order combination at the time of death remains 'do not resuscitate and comfort measures only,' there was a rise in orders for more aggressive life-sustaining treatments," says Tolle.

For example, about 13% of POLST forms completed by those who died between 2015 and 2016 requested CPR, and 11% requested full medical treatment, compared with about 8% and 6%, respectively, in the earlier cohort.

"We have explored possible reasons, and in response have taken a first step by creating a policy recommendation advising against counting POLST forms as a quality measure," says Tolle.[2]

• Patients with Alzheimer's and Parkinson's often complete POLST forms earlier in their disease than in their final year of life.

The 2019 Oregon POLST form was modified based on these and other findings. "The reasons for each of these changes may be of interest to ethics leaders in other states," says **Valerie Jimenez**, BS, executive director of the Oregon POLST Coalition. These changes were made:

• The artificially administered nutrition section was removed.[3]

• The "P" in POLST was changed from "Physician" to "Portable" to include nurse practitioners and physician assistants.

• The form was changed from solid pink to a pink border.

"This was because of compromised quality or readability on fax or photocopy transmissions from one care setting to another," explains Jimenez. ■

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CME/CE QUESTIONS

1. **Which financial conflicts of interest influence whether studies report findings favorable to industry sponsors, according to a recent study?**

   a. Only undisclosed conflicts of interest.
   b. All financial conflicts of interest.
   c. Only relevant conflicts of interest.
   d. Only conflicts of interest with more than $50,000 or more of payments.

2. **Which is true regarding researchers' financial conflicts of interest, according to Matthew McCoy, PhD?**

   a. Benefits clearly outweigh the risk of bias for the majority of funded research.
   b. Given the potential for bias, it is important that all conflicts be disclosed so they can be evaluated.
   c. Disclosure neutralizes the risk of bias.
   d. Research institutions are required to revise conflicts of interest policies due to increased scrutiny.

3. **Which is true regarding palliative medicine skills in the ED setting?**

   a. ED providers opposed a nationally defined hospice and palliative medicine curriculum for resident training.
   b. Residency programs are required to cover palliative medicine skills.
   c. Few physicians are board-certified in both emergency medicine and palliative medicine.
   d. All training programs now have palliative care "champions" to advocate for the inclusion of these skills.

4. **Which is true regarding surrogate identification?**

   a. Alcoholism automatically disqualifies an individual from serving as surrogate.
   b. All state laws have some degree of flexibility to if the person with the highest priority on the list is not the best choice.
   c. Social workers cannot legally assist in surrogate selection according to federal law.
   d. A healthcare surrogacy law gives the surrogate authority to make healthcare decisions for patients who have not appointed an agent in a power of attorney for healthcare.